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	155530	A. BUILDING 00 B. WING	02/03/2015

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F000000	This visit was for the Investigation of Complaint IN00162397. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00161017 completed on December 29, 2014. Complaint IN00162397- Substantiated. Federal/State deficiency related to the allegations is cited at F323. Survey date: February 3, 2015 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Survey team: Janet Adams, RN-TC Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 11 Medicaid: 58 Other: 4 Total: 73	F000000	Please accept the following as the facility's credible allegation of compliance. This plan does not constitute an admission of guilt or liability by the facility and is submitted only in response to regulatory requirements. The facility hereby respectfully requests a desk review of the alleged deficiencies noted in this survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 5 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on Febraury 4, 2015 by Jodi Meyer, RN			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview the facility failed to provide adequate supervision related to fall interventions and devices not in place for 2 of 3 residents reviewed for falls in the sample of 5. (Residents #C and #D) Findings include: 1. On 2/3/15 at 10:00 a.m., Resident #D was observed sitting in a wheel chair next to her bed. There was no alarm box	F000323	The facility will continue to ensure that resident environments remain as free of accident hazards as is possible, and that residents receive adequate supervision and assistance devices to prevent accidents. **What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C is no longer a facility resident. An alarm box was immediately attached to Resident #D's	02/28/2015

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	attached to the wheel chair. There were no staff members or visitors in the room at that time. On 2/3/15 at 10:05 a.m., LPN #1 assisted the resident to a standing position from her wheel chair. There was a padded cushion on the seat of the wheel chair. There was no Dycem on top of or under the seat cushion. There was no wheel chair alarm in place. The record for Resident #D was reviewed on 2/3/15 at 9:55 a.m. The resident's diagnoses included, but were not limited to, depression, seizures, high blood pressure, and diabetes mellitus. The 2/2015 Physician Order Statement was reviewed. There was an order for the resident to have a Dycem (plastic film to prevent slipping or sliding) pad on the wheel chair. The order was originally written on 6/18/13. There was also an order for the resident to have wheel chair and bed alarms in place. The order was originally written on 11/1/13. The 12/7/14 Minimum Date Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive patterns were moderately impaired. The assessment		wheelchair. Further, a bed alarm was and continues to be in place for Resident #D's bed. Additionally, a padded cushion was immediately placed on the seat of Resident #D's wheel chair and Dycem was immediately placed under the seat cushion. Additionally, resident #D has been re-assessed and appropriate interventions are in place, based on current assessment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Facility residents will be re-assessed by charge nurses or designees to ensure that resident environments continue to be safe and free of accident hazards as is possible. As a result of resident assessments/re-assessments, individualized interventions will continue to be implemented or modified as indicated and appropriate. Residents will continue to receive adequate supervision and appropriate assistance devices to prevent accidents as is possible. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not reoccur?** Upon admission, new residents will continue to be assessed by charge nurses or designees to ensure that their environments are free of accident hazards as is	

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	also indicated the resident required extensive assistance of one staff member for bed transfers, bed mobility, and walking in the room or corridor. The assessment also indicated the resident was not steady with transfers moving from a seated to a standing position. A Fall Risk assessment was completed on 1/22/15. The resident's score was (22). A score of (10) or above indicated the resident was at risk for falls. The last Fall Risk assessment completed prior to 1/22/15 was completed on 6/2/14. The 6/2/14 Fall Risk assessment score was also (22). The resident's current Care Plans were reviewed. A Care Plan initiated on 3/11/14 indicated the resident has impaired cognition, decreased strength and endurance, and a history of falls. The Care Plan was last reviewed on 12/9/14. Care Plan interventions included for the resident to have a Dycem in place to the wheel chair. The 2/2015 Treatment Record indicated the following treatments were to be in place included for the resident to have bed and wheel chair alarms in place every shift and a Dycem pad on the wheel chair while up in the wheel chair.		possible. Based on such admission assessments, individualized interventions will be implemented. New residents will be provided adequate supervision and appropriate assistance devices to prevent accidents as is possible. Further, an ongoing facility QA audit will be conducted by charge nurses or designees to ensure that interventions initiated continue to be in place, as indicated. Any deviations will be corrected immediately and a root cause analysis determined and appropriate follow-up initiated. Additionally, staff will be re-educated regarding properly assessing and monitoring resident safety issues to ensure that resident environments are free of accident hazards as is possible. Further, in-services shall stress the vital importance of adequate supervision, monitoring and providing appropriate assistance devices to residents to prevent accidents as is possible. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Upon admission, an assessment form entitled “Initial Resident Safety Assessment” will be conducted and forwarded to the Director of Nursing or designee to review for accuracy. Such form will address interventions for any potential accident hazards,	

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	The 1/2015 Nurses' Notes were reviewed. An entry made on 1/22/15 at 7:00 a.m. indicated the Nurse was called to the resident's room. The CNA stated she had dressed the resident and had been trying to get the resident up into the chair and the resident slid on the floor. No injuries or bruises were noted. The resident had no complaints of pain or discomfort. When interviewed on 2/3/15 at 10:15 a.m., LPN #1 indicated the resident was to have a Dycem pad in place on her wheel chair. When interviewed on 2/3/15 at 10:20 a.m., CNA #1 indicated she was assigned to care for Resident #D. The CNA indicated she usually worked on another hall. The CNA indicated the resident was gotten up into the wheel chair by the night shift staff. The CNA indicated she did not have any care card or instruction sheet for interventions to be in place for Resident #D. When interviewed on 2/3/15 at 1:35 p.m., CNA #1 also indicated she did not receive report or instructions from the Nurse or the night shift CNA related to the use of alarms or Dycem pad for the resident. When interviewed on 2/3/15 at 1:30 p.m.,		supervision needs and appropriate assistance devices, if indicated. The QA audit form entitled “Ongoing Resident Safety Assessment” will be initiated by charge nurses or designees. Such form will validate that interventions are in place and that assessed residents' environments continue to be free of accident hazards as is possible. Additionally, this QA audit form will validate that assessed residents are receiving adequate supervision and appropriate assistance devices to prevent accidents as is possible. Any deviations will be corrected immediately and a root cause analysis determined and appropriate follow-up initiated. QA audits will be conducted by charge nurses or designees not less than twice daily a minimum of 5 times per week for 90 days. Thereafter, such QA audits will be conducted not less than once daily for 120 days. The results of such audits will be reviewed by the Director of Nursing or designee and the Quality Assurance Committee for appropriate recommendations and action, if indicated. Unannounced random QA audits will be conducted not less than weekly for 60 days by nurse managers or designees. Thereafter, such random QA audits will be conducted not less than monthly for 120 days. Any deviations will be corrected	

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	the Director of Nursing indicated the resident should have had the Dycem and chair alarm in place as per the Physician's order and plan of care. 2. The closed record for Resident #C was reviewed on 2/3/15 at 9:31 a.m. The resident's diagnoses included, but were not limited to, right hip fracture, hematoma of the forehead, advanced dementia, altered mental status, seizures, osteoarthritis, and anemia. The resident was admitted to the facility on 12/24/14. The 12/24/14 Nursing Admission Assessment listed right hip fracture as the resident's admitting diagnosis Review of the 12/24/14 Fall Risk assessment indicated the resident's score was (12). The assessment indicated the resident had 1-2 falls in the past three months and was chair bound. The Fall Risk assessment also indicated if the residents were at high risk for falls a prevention protocol was to be initiated immediately and documented on the care plan. Review of the 12/24/14 Side Rail Assessment screen indicated the resident had a history of falls and had an alteration in safety awareness due to cognitive decline.		immediately and a root cause analysis determined and appropriate follow-up initiated. The results of such audits will be reviewed by the Director of Nursing or designee and the Quality Assurance Committee for appropriate recommendations and action, if indicated. **Bywhat date the systemic changes will be completed?** February 28, 2015.	

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	A Care Plan initiated on 12/25/14 indicated the resident was at risk for falls related to a history of falls, decreased safety awareness, cognitive impairments, and impaired range of motion. Care plan interventions included to ensure the call light was in reach, low bed, floor mats x 2, and encourage resident to use the call light for assistance. The 12/2014 Nurses' Notes were reviewed. An entry made on 12/24/14 at 8:00 p.m. indicated the resident arrived to the facility via an ambulance transport. The entry also indicated the resident had a right hip fracture with 14 staples intact. The entry also indicated the resident required total care from the staff. The next entry in the Nurses' Notes was made on 12/25/14 at 1:30 a.m. The entry indicated the resident was in bed with her eyes closed and the call light was in reach. The next entry was made on 12/25/14 at 5:30 a.m. The entry indicated the resident remained in bed and the dressing to the right hip was intact. An entry made on 12/25/14 at 9:30 a.m. indicated the Nurse was making round and noted the resident on the floor. A head to toe assessment was completed, the resident was able to move three			

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	extremities well, and the right leg moved slowly. No facial grimacing or complaints of pain were noted. The Physician and family were notified and the resident was to be sent out to the hospital for further evaluation. An Initial Fall Investigation form dated 12/25/14 was reviewed. The form indicated the resident fell in her room and was in the bed prior to the fall. The form also indicated the resident was confused and did not have a low bed or bed alarms in place. The form also indicated Interventions to prevent recurrence were to be mats on either side of the bed. When interviewed on 2/31/5 at 9:45 a.m. LPN #1 indicated she participated in completing Care Plans and she was did not initiate any Care Plans for Resident #C on 12/24/14 or 12/25/14. The MDS (Minimum Data Set) Nurse was also interviewed at this time and indicated she had not completed any Care Plans for the Resident on 12/24/14 or 12/25/14. The MDS Nurse also indicated staff Nurses were to initiate Care Plans upon admission if needed. When interviewed on 2/3/15 at 11:20 a.m., RN #1 indicated she had been assigned to care for Resident #C on the day shift on 12/25/14. RN #1 indicated			

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	she observed the resident on the floor and completed a head to toe assessment at that time. The RN indicated the resident had a right hip fracture with sutures in place also at that time. RN #1 indicated the resident was lying on the floor on her side and floor mats were not down. The RN also indicated the resident was not in a low bed though the regular bed she was in was in the lowest position that the regular beds go to. RN #1 indicated she placed floor mats after the resident fell as they were expecting the resident to return to the facility from the hospital. The RN also indicated she did not complete or update any Care Plan for the resident after the fall. When interviewed on 2/3/15 at 11:30 a.m., the Director of Nursing indicated when a resident has a fall the Nurses were to complete an incident report, complete an Initial Fall Investigation form, and update the Care Plans. The Director of Nursing indicated she was unable to identify when the above 12/25/14 was initiated and/or updated related to the resident's fall. This Federal tag relates to Complaint IN00162397. 3.1-45(a)(2)			

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